Access to Primary Care Physicians for Medicaid and Medicare Patients in Five Rural Washington Counties

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Executive Summary

The Office of Community and Rural Health, Washington State Department of Health, surveyed practices to determine the amount of direct care provided by primary care physicians in Clallam, Kittitas, Jefferson, Lewis and Whitman counties between November 2001 and April 2002. The survey specifically addressed access for Medicare and Medicaid patients.

- In three of the five counties, providers were less likely to accept new Medicare patients than new Medicaid patients.
- In Clallam and Kittitas counties only 20% of primary care physicians reported they would take new Medicare patients.
- In Kittitas County less than one-half of the practices were open to any new patients because of a general shortage of providers.
- In four of the five counties, most practices were open to employer insured and self-pay patients.

As is the case in most of the rural United States Medicare managed care options were not available (one county) or very limited (three counties). And in the fifth county very few providers were accepting new Medicare managed care patients. Providers were slightly more likely to report accepting new Medicaid Fee for Service patients than Medicaid Managed Care patients (Healthy Options).

There is anecdotal evidence from Lewis County suggesting a link between Rural Health Clinic (RHC) status and Medicare and Medicaid access. Providers in outlying practices, most of which are RHCs or eligible and applying for that status, were much more likely to accept new Medicaid or Medicare patients. These same practices also have larger Medicaid FFS and Medicare shares than providers working in practices without RHC status.

Practices (and providers) with greater combined Medicare and Medicaid shares were less likely to be open to either Medicare or Medicaid patients. Whitman county providers have significantly lower combined Medicaid and Medicare shares (40%) than the other four counties surveyed (60%). Whitman county providers were almost twice as likely to accept new Medicaid and Medicare patients than providers in the other four counties. These findings are consistent with results of the 2001 *State Primary Care Provider Study*,

sponsored by the Health Care Authority and Department of Social and Health Services, which found rural practices with high Medicaid and Basic Health Plan shares were associated with poorer financial performance.[1]

In all five counties, most patient primary care is tax financed. Between 70% and 75% of primary care patients are covered by Medicaid, Medicare or have health insurance through a government employer. This is generally consistent with national data – although rural health care services tend to be somewhat more tax dependent than urban health care services.

Background

Starting in the fall of 2001, the Office of Community and Rural Health, Washington State Department of Health has modified Health Professional Shortage Area (HPSA) surveys to make them more useful for understanding access to primary health care. These surveys are conducted on a three-year cycle and are necessary for specific areas to qualify for Federal HPSA status. While HPSA status is voluntary, it establishes eligibility for several federal assistance programs. The original survey included questions such as:

- How much direct care is provided to patients?
- What are relative patient shares for Medicaid FFS and Medicaid Managed Care, Basic Health Plan and Sliding Fee Scale?
- Are specific primary care providers taking any new privately insured, Medicaid, or Sliding Fee Scale patients?

The survey was modified to make the tool more useful in identifying primary care practices that are accepting new Medicare and Medicare+ Choice patients. Although Medicare access questions are not required for purposes of designation they are essential for understanding access to primary health care. These changes were adopted in two cycles. In the first revision practices were asked if they were taking new Medicare patients, this survey version was administered in Clallam (excluding the town of Forks) and Kittitas counties.

In Spring 2002, the second cycle questions were added to differentiate between Medicare FFS and Medicare+ Choice, obtain information on estimated Medicare shares, and identify physician specialty. This survey version was administered in February through April in Jefferson, Lewis, and Whitman counties. The revised survey in its entirety is currently being administered in Thurston, Yakima, Chelan, Douglas, and Spokane counties. These findings will be available later in the summer.

HPSA survey data offer a useful snapshot of access to primary health care. But results should be interpreted with some care. Limitations of this study include:

- It covers only access to primary care *physicians* (*Family and General Practice, General Internal Medicine, General Pediatrics, and General OB/GYN*), therefore Nurse Practitioners and Physician Assistants are not included. Access to specialty

care may also be a concern. The lack of specialists accepting referral for Medicaid or Medicare patients may be a factor influencing whether primary care physicians are willing to accept these patients.

- It is self-reported. When possible the survey is administered to the clinic manager who is often more aware of payment systems then are providers. Others have found that most self-reports on Medicare and Medicaid activity are over-estimated. Access may be even lower than is reported here.

- The survey is a snapshot of existing conditions. As this is a new survey, historical data on whether access for existing patients has changed is not available.

- Direct comparisons between Medicaid and Medicare access should be made cautiously. Medicare patients use more specialty care (not included here) and are less likely to be seen by pediatricians (who are included).

Overview of Medicare, Medicaid and Basic Health Plans

This overview is extracted from the Introduction to Health Care Services section of the Health of Washington State, 2002.[2]

Medicare. This federally funded program primarily for people 65 and older provided health insurance to 725,000 Washington enrollees in 1999. Medicare provides coverage for hospitalization (Part A), physician services (Part B,) and some long-term care. It does not currently cover prescription drugs, preventive services, and selected other health services. Consequently, 43% of Medicare beneficiaries in the 2000 Washington State Population Survey reported they had policies that supplement Medicare coverage. In November 2001, 20.9% of Medicare enrollees in Washington were enrolled in Medicare+ Choice, Medicare's managed care option[3]. But Medicare managed care options in rural areas are limited. Consequently, only 12.8% of Medicare enrollees in Washington's non-metropolitan counties are enrolled in Medicare+ Choice plans in 1999.[4]

Medicaid. This state-federal health insurance program for low-income people covered 688,000 Washington residents in 1999. Medicaid primarily covers people currently and formerly on public assistance with family incomes within 200% of the federal poverty line, including Temporary Assistance to Needy Families (TANF), and people with disabilities. Children who are not eligible for TANF but have family incomes within 250% of the federal poverty line can enroll in Medicaid through the State Children's Health Insurance Program (SCHIP). About 58% of average monthly Medicaid enrollees are assigned to Healthy Options, Washington's Medicaid managed care option.[5] Welfare reform, which moved thousands of Washington families off public assistance, caused a 2.4% drop in Medicaid participation from 1997 to 1999. More recently, enrollment has been increasing as a result of the state's faltering economy, an increase in households unable to cover extraordinary health costs, and implementation of SCHIP. Medicaid enrollment in fiscal year 2002 is projected to be about 800,000, and in March 2002 there

were 862,000 persons served by Medical Assistance Program, with another 72,000 people receiving family planning services.[6]

Basic Health (BH). The BH program is administered by the Washington State Health Care Authority to provide subsidized health insurance to low-income individuals who do not qualify for Medicare. In 2000, more than 217,000 state residents received coverage through the BH program or Basic Health Plus (BHP), for Medicaid children enrolled in BH. During the 1990s, the program offered Washington residents a chance to purchase unsubsidized insurance coverage through the BHP. This unsubsidized option is no longer offered, and fewer than 1,000 people remain under this coverage. Subsidized BHP coverage was capped at 131,250 in 2000, and the cap was lowered to 125,000 in 2001.[7] An additional 56,000 children were enrolled in BHP in December 2001. With passage of Initiative 773 in 2001, funding could be available for an additional 20,000 to 30,000 BHP enrollees.

County Profiles

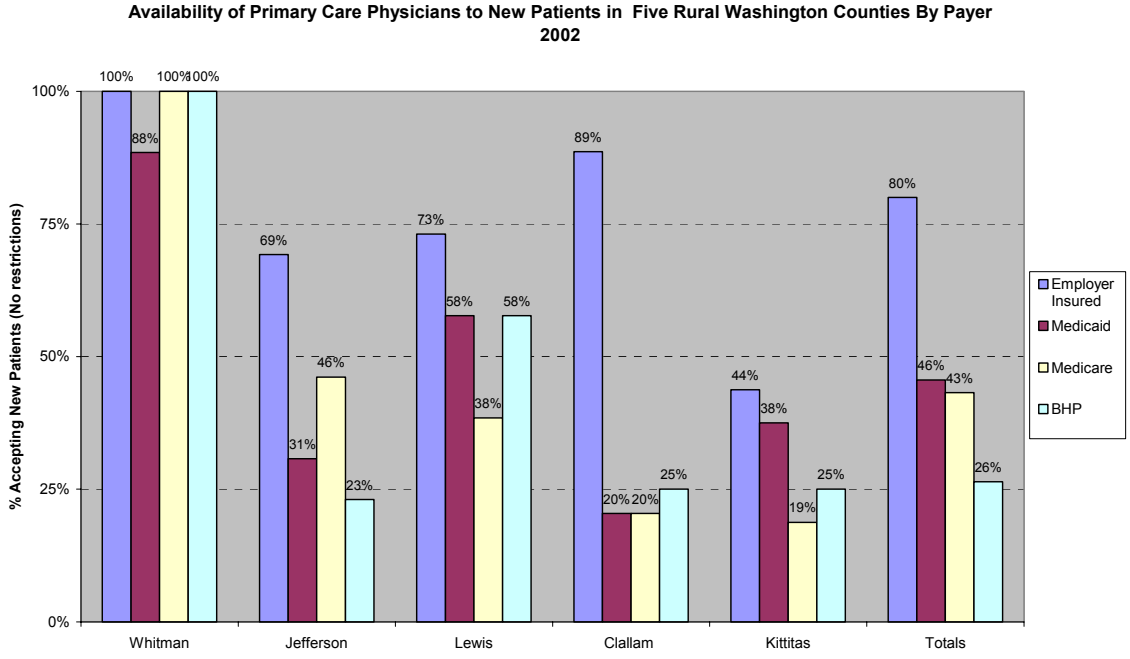
County	Population (2001)	% Below 200% of FPL (1998)	% Over Age 65 (2001)	# of Primary Care Providers (% Peds)	# Healthy Options Plans	# Medicare+ Choice Plans	# of BHP Plans	CMHC* Clinics	Rural Health Clinics
Clallam	64,800	36%	21%	44 *** (NA)	1	2**	1	None	Forks (3) Clallam Bay (1)
Jefferson	26,100	34%	21%	13 (31%)	1	1**	1	None	Quilcene (1)
Kittitas	34,000	42%	12%	16 (31%)	1	2**	1	None	Cle Elum (1)
Lewis	69,500	38%	15%	26 (27%)	2	5	2	None	Outside Chehalis and Centralia (7)
Whitman	40,300	40%	9%	32**** (NA)	1	0	2	None	Tekoa (1)

* Community and Migrant Health Center
**Available plans have fewer than 100 participants.
*** Does not include seven providers in Forks.
**** Includes six providers at Washington State Health Services that were not surveyed in this study.

Although all five counties are rural they range in population from 26,000 (Jefferson County) to 69,000 (Lewis County) and they all have high poverty rates. Port Angeles in eastern Clallam County also serves as a regional medical center. While comparable in population to Lewis County, Clallam County has more primary care providers, especially those in General Internal Medicine. The Rural Health Clinics in these areas are small clinics, in outlying areas. Many of the remaining clinics are in the RHC application process.

Findings

Primary care physicians in the five counties are less likely to accept new Medicare, Medicaid and the Basic Health Plan patients than insured or self-pay patients. In 3 of 5 counties, the percentage of primary care providers open to new Medicare patients with no restriction was lower than the percentage open to Medicaid patients. This gap widens when providers that accept new Medicaid or Medicare patients on a restricted basis are included. If providers only accepting new Medicaid patients for Obstetric care are counted as "open", the percentage of "open" Medicaid providers increases from 20% to 27% in Clallam County and from 58% to 81% in Kittitas County. In Lewis County, the percentage of providers accepting new Medicare patients increases from 38% to 50%, when providers limiting new Medicare patients to those participating in the Group Health Medicare+ Choice plan (and not taking FFS or those signed up for the other four plans in the county) are included.



With the exception of Kittitas County, most practices are accepting new patients with employer-based insurance. This suggests that general physician shortages are not the major cause of the number of practices closed to Medicare and Medicaid patients.

About 20% of the primary care physicians are pediatricians. Pediatricians are more likely to report they are closed to Medicare patients because they are outside their scope of practice. Only a small number of Medicare eligible patients are dependents or surviving minors. Since we did not collect information on provider specialty uniformly, we could not exclude them from calculations. The affect of excluding pediatricians in Medicare access calculations differs by county. In Lewis County 7 of 27 primary care physicians (26%) are pediatric specialists, none of whom saw Medicare patients. With pediatric specialists excluded the percentage of primary care providers seeing Medicare patients increases from 38% to 50%. But in Jefferson County both pediatricians did see Medicaid patients and in Whitman County, there were no pediatricians. On the other hand, the percentage of providers accepting new Medicaid patients may be lower than other rural counties since none of these counties has a Community and Migrant Health Center and few of the practices are currently Federally certified as Rural Health Clinics.

Jefferson and Lewis Whitman Counties -- A more detailed look

The more detailed data collected in Jefferson, Lewis and Whitman counties allows an examination of differences in the number of open providers between Fee for Service and Managed Care options of both Medicaid and Medicare. As shown in the following chart, slightly fewer providers report accepting new Healthy Options patients relative to Medicaid FFS. The difference is considerably more dramatic for Medicare Managed Care. No Medicare+ Choice plans are available in Whitman county, one very limited plan is offered in Jefferson and only 12% of providers reported accepting both Medicare+ Choice plans offered in Lewis county. In Lewis County an additional 12% reported accepting only one of the five available Medicare + Choice plans. These results are consistent with national analyses indicating Medicare+ Choice is seldom available in rural areas[8].

Medicare and Medicaid Dependence and Access–Whitman County Example

Why are more practices in Whitman County open to Medicare and Medicaid than in the other four counties studied? Whitman County is unique and strongly influenced by the location of a major state university, Washington State University, in Pullman. Consequently the population is much younger (not eligible for Medicare) and more likely to have health insurance due to employment associated with the University. The state (including higher education), local, and federal government employs over 60% of the Whitman County workforce.

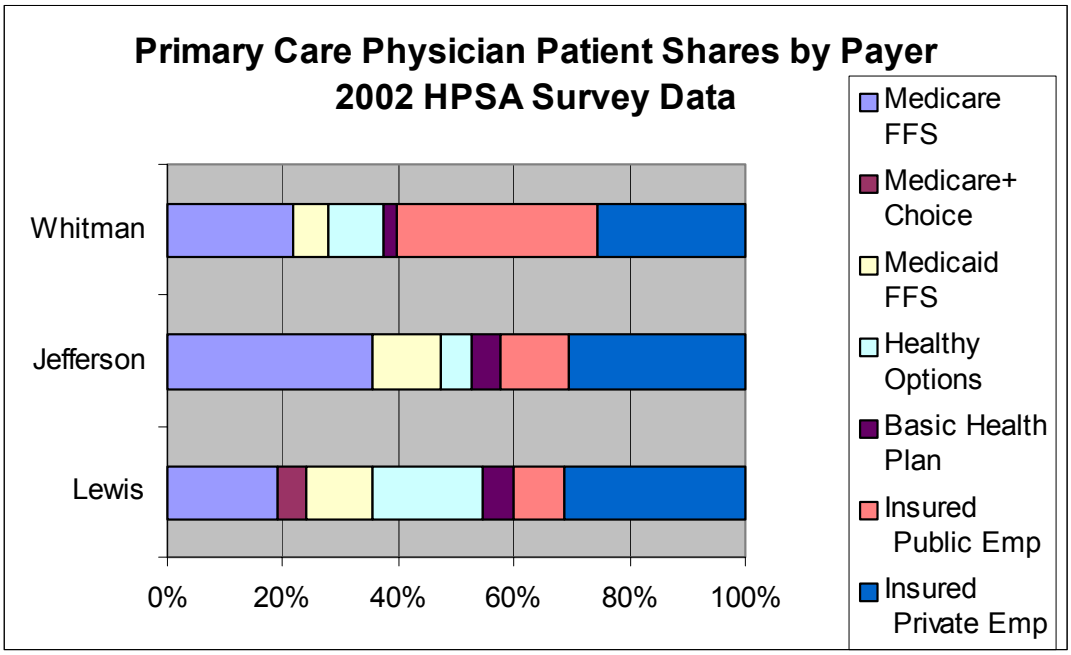
A greater share of Whitman County primary care patients have employer-based health insurance relative to the other counties in the study. In the last table, on the following page, Whitman County physician offices reported Medicaid or Medicare covered 40% of their primary care patients. In contrast, Jefferson and Lewis county providers reported that Medicare or Medicaid covered 60% of patients. The larger insured base in Whitman county supports more providers per capita than each of the four other counties, which spreads the Medicare and Medicaid population over more providers. It may be that practices in the other four counties may be more 'saturated' relative to existing Medicare and Medicaid reimbursement levels.

Rural Health Care – A Tax Financed System

The chart on the following page summarizes patient shares by payment source adjusted for full time equivalence (FTE).[9] Although the distribution of patients by payer source differs in all three counties, the primary health care of between 70% and 75% of patients in these five counties is completely or partially tax financed through Medicare, Medicaid, or insurance offered to federal, state and local government employees or their dependents. This is likely to be an underestimate of the share of total health care expenditures that are tax financed. Not accounted for are "hidden" publicly financed health care expenditures such as health care expenditures for those in prisons and jails, and the fact that Medicare covers an even larger share of hospitalization costs than private insurers.

The proportion of those insured as employees or as dependents of federal, state and local government employees was estimated using 2000 Labor Market Employment Analysis branch county industry employment data.[10] This was adjusted to reflect health insurance rates by industry using an approach developed by Bunting (2001), for estimating county health insurance rates.[11] According to the 2000 Washington State Population Survey 93% of government employees had health insurance available to them. In contrast, 54% of workers in businesses with 10 or fewer workers offer insurance.[12] The estimates of the relative share of employer insured patients who are public employees reported here are likely to be underestimates.. The industry health insurance rates were developed from national and state studies. Rural businesses are smaller and less likely to offer health insurance or, if willing, able to even find an affordable plan.

Health care services in rural areas are more likely to be tax financed than the health care services provided in urban areas. But tax expenditures are still the largest payment source in all areas of the country. In 1998, 51% of national health expenditures were tax financed, 27% were private-employer financed, and 22% were paid directly out-of – pocket.[13]



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[8] See for example Casey M Knott A Moscovice I. Medicare minus choice: the effect of HMO withdrawals on rural medicine beneficiaries. Health Affairs 21 (3) May June 2002.

[9] One full time equivalent = 40 hours of direct patient care. This adjusts for those working part time or in administrative or educational roles.

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